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‘Power to the people? An international review of the democratizing potential of direct elections to healthcare organisations.’

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Power to the people? An international review of the democratizing effects of direct elections to healthcare organizations

Introduction

Managing a modern healthcare system is a complex challenge, but in countries which aspire to universal, publicly-financed care this is a challenge in which the public has a significant investment. Although the details of how care can best be provided often depend on detailed professional knowledge, there is a demand that professionals and managers should be accountable to the public at a local level (Hunter & Harrison, 1997). In theory, the accountability of health care providers in publicly-funded health systems is clear: providers report to the minister, who in turn reports to the legislature, which in turn reports to the electorate. However this has not always been perceived as successful in practice. The sheer size of health systems, and the fact that many issues besides health policy determine national electoral outcomes, means that there are too many obstacles between the transmission of local voters' preferences and the system they get.

One way to enhance democracy without, as in some Scandinavian systems (Martinussen & Magnussen, 2009), involving local government is to have specific elections to boards in intermediate health services bodies. Potentially, such elections could have broad benefits: tighter local accountability for local decision makers, broader and perhaps more descriptive representation of the community on the boards, decisions reflecting the salience of local issues, and reinvigorated public engagement. They could also have costs: unrepresentative interests winning power in low-turnout elections, politicization and conversion of boards into party political arenas, or rebellious boards that declined to accept the still-existing hierarchically subordinate relationship with the ministers who set policy, law, and their budgets.

This review proposes a conceptual framework by which the democratizing effects of elections to healthcare organizations can be judged, and considers evidence from elections in Canada, England, New Zealand and Scotland. While the evidence suggests that both the highest aspirations and the greatest fears associated with such initiatives were largely unfounded, their democratic credentials are rarely convincing.

The dual role of elected boards: managing and democratizing public services?

The Boards of major public sector organizations face a unique and challenging brief. The very concept of 'a Board' originates in the private sector (Cornforth, 2005), and accordingly they are expected to provide technically-sound oversight of organizational performance, improving the efficiency and effectiveness of the organization. However, reflecting the unique characteristics of public organizations, these Boards are also held to standards of

transparency and responsiveness to stakeholders and the publics that they serve. The idea of electing Boards stems from these concerns. In a final constraint, they work to a budget and often to standards set by central government (Cornforth, 2005; Skelcher, 1998). The literature on elected Boards demonstrates all three of these concerns: this review is concerned specifically with the democratizing effects of elected Boards.

The task of assessing progress towards democratizing a health system is hampered by the complexity of the concept of democracy. Indeed health policymakers across three continents have turned to elections in search of greater legitimacy and accountability, just as contemporary democratic scholarship is replete with calls for non-electoral innovations to compensate for the apparent failures of representative democracy (Norris, 2002; Santos et al., 2007; Smith, 2005). In a classic text, Schmitter and Karl (1991, p. 76) define democracy as: “a system of governance in which rulers are held accountable for their actions in the public realm by citizens, acting indirectly through the competition and cooperation of their elected representatives”. However the practical implications of calls to ‘democratize’ health systems are not self-evident, and the presence of elections does not, in any simple sense, equal democracy but requires a set of additional features to be present (Schmitter & Karl, 1991).

Drawing on Pitkin’s (1967) seminal account of representation, Urbinati and Warren (2008, p. 396) propose the following definition of democratic responsiveness: “(a) authorization of a representative by those who would be represented, and (b) accountability of the representative to those represented”. In other work we have used this conceptual framework to assess the extent to which a specific instance of elections to healthcare organizations succeeded in democratizing the organizations (Greer et al 2014b). For the purposes of this wider review of international evidence, and informed by the recurrence of an additional set of democratic concerns within the published literature on elected health boards, we add a further criterion. In a subsidiary election - such as one mandated by central government elected representatives to take place at a lower level of public administration – we would argue that there is a risk of tokenistic elections being held where little is at stake. Accordingly, to the criteria of authorization and accountability, we add one of ‘influence’, assessing whether elected representatives were able to yield any significant decision-making power once in office.

Materials and methods

While there is a substantial literature on these topics, it does not consistently address questions of democratization. As others have acknowledged (Barnett & Clayden, 2007), the primary research on Board elections mostly focuses on the views of Board members and so it is difficult to identify wider impacts: this reflects a broader preoccupation in the literature with accounts of process (such as election administration) rather than assessments of outcomes (such as degree of democratization) (Mitton, Smith, Peacock, Evoy, & Abelson, 2009). Where authors have considered the extent to which elections have ‘delivered’ democratization, there has been little attempt to specify the conceptual nature of these goals, and the analysis has concentrated on evidence from New Zealand, the most established and thoroughly-researched of the elected systems (Gauld, 2005).

Our review proceeded in a two-step process, beginning in 2010. First, we identified comparable cases of election to healthcare organizations, by internet searching and contacting

experts in the field. We focused our search for cases on the distinct challenges associated with accountability of service-providing organizations in countries with closely comparable health systems. This excludes, for example, elections to sickness funds in Germany (Haarmann, Klenk, & Weyrauch, 2010). We then conducted literature searches to identify evidence on the characteristics of the actual elections, and their impact on both organizational behavior, and organizational relationships with the public. Searches of Web of Knowledge and Google Scholar were undertaken to identify the published academic literature on the previously identified cases of elections to healthcare organizations. ‘Grey’ literature sources such as each province or country’s government websites were then searched. Bibliographies and references from all sources were checked for further relevant references. The literature search was updated in February 2014 using the Web of Science database.

Cases

Our review identified four cases of direct elections being held for boards of governance of healthcare organizations in tax-funded health systems: in some Canadian provinces in the 1990s; in New Zealand for several periods including most recently from 2000 to the present; in England from 2004 to the present; and a (now discontinued) pilot in Scotland in 2010. The cases of Canada, New Zealand and Scotland involved elections to closely comparable entities: the boards of directors who run territorial health planning organizations. By contrast, elections to England’s Foundation Trusts are for a Board of Governors which then oversees the board of directors of a hospital or other provider organisation. Elected members are thus not themselves decision-makers, but are charged with offering views to and appointing the eventual decision-makers. Additionally electors are (in almost all cases) the self-selected ‘membership’ of the Foundation Trust rather than all the residents of an area served by the organization. While, therefore, something of an outlier within this review, the English case does bring the methods of representative democracy into the governance structure of healthcare organisations, and, as will be demonstrated below, many of the debates in the published evidence on FTs are consistent with those in the literature from the other cases. For the purposes of this review, the most salient point is that this governance structure creates an opportunity whereby any interested member of the public can, after applying for membership, vote to elect individuals who play a significant role in the governance structure of that organization.

England: Foundation Trusts (FTs) were created in the English NHS in 2004. They have an unusual governance structure consisting of a membership made up of local people (generally citizens who choose to sign up as members), who then elect a Board of Governors (Department of Health, 2010). Day and Klein (2005, p. 8) argue that the rationale for these elections was, rather than a broad-based democratic accountability to the local public, “designed to make the notion of giving independence to providers acceptable to Labour Party traditionalists”. Policy documents described this structure as modelled on co-operative and mutual traditions, but commentators argue there is no evidence that FTs have fulfilled this brief (J. S. F. Wright, Dempster, Keen, Allen, & Hutchings, 2012). FTs operate under ‘earned autonomy’, with their Board of Directors held to account by this Board of Governors, rather than the Strategic Health Authority (Dixon, Storey, & Rosete, 2010). Each Foundation Trust has discretion in how to arrange both membership and elections, resulting in considerable diversity of method and Board structure (Day & Klein, 2005). However certain statutory provisions exist including:

- Governors appoint the Chair and non-executive members to the Board of Directors
- Governors can dismiss the Chief Executive with a 75% vote
- Boards of Governors consist of a majority of elected members (both staff and public/patient) and a minority of appointed stakeholder members (from Primary Care Trusts etc) (House of Commons Health Committee, 2008).

Canada: As part of a major programme of ‘regionalization’ during the 1990s, Canadian provinces devolved more decision-making power to local organizations, and this process involved calls for elected health boards (Church & Barker, 1998; Lewis et al., 2001). While these calls were at least to some extent rooted in a commitment to public participation, Phillipon and Braithwaite (2008, p. 175) stress that “a fiscal imperative underlined many of those objectives”. Canada has the largest number of experiments with elected health boards, but by far the smallest primary research literature, and much of the literature we found examines one province, Saskatchewan (Lewis et al., 2001). Saskatchewan created Regional Health Authorities in 1992 and moved to a system of partially elected Boards in 1995. Two thirds of the membership of each Board were elected on a ward basis, with one third appointed. Three elections took place, at the same time as municipal elections. We know that - in addition to Saskatchewan - Alberta (from 2001-2004) (Government of Alberta, 2001), New Brunswick (from 2004-2008 and again since 2012) (Elections New Brunswick, 2012; Government of New Brunswick, 2008), Prince Edward Island 1999-2005) (Government of Prince Edward Island, 1999; Phillipon & Braithwaite, 2008) and Quebec (1992-2001) (Abelson et al., 2002) have all experimented with elected Boards, although we could identify very little primary research on these cases. Reasons given in official documents for the abandonment of elections include the managerial (including the financial costs of elections and the need to ensure a particular skills mix on Boards) and the democratic (concerns about low levels of turnout and candidacy).

New Zealand: District Health Boards in New Zealand are responsible for arranging all health services for their populations, and additionally own and manage public hospitals. Direct elections to District Health Boards were instituted in 2000 (New Zealand Ministry of Health, 2014), but there had previously been directly elected Area Health Boards for a spell in the 1980s, and elections have also have a longer history in the country’s health system (Laugesen & Gauld, 2012). Barnett et al (2009, p. 120) attribute the abolition and reintroduction of elected Boards to the ideological inclinations of incoming Governments, within the broader context of “a century-long tradition of health democracy and locally elected hospital\health boards”. District Health Boards have up to 11 members, seven of whom are elected and four appointed by the Minister of Health, with the intention of enhancing the skill base and community representation of the Board. This mechanism ensures that at least two Board members are of Maori origin. Our review suggests that the New Zealand case has been subject to the most comprehensive research of the four, with a series of substantial voter surveys accompanying qualitative research on the resulting elected Boards (see for example Barnett & Clayden, 2007; Gauld, 2005, 2010).

Scotland: In Scotland, the Health Boards (Membership and Elections) (Scotland) Act 2009 introduced pilots of direct elections to two territorial Health Boards in 2010. This legislation gained cross-party support in parliament against a background of highly-publicized and unpopular decisions made by the previously appointed Boards (Greer et al 2014a). Fourteen of these “territorial” boards provide a wide range of health services, from public health and some primary care to hospital care, in their areas across Scotland. The elections were held in

summer 2010 by postal ballot. A sufficient number of non-executive board members were elected in each Board area to ensure that the Board had an overall majority of elected members (as compared to executive members (from NHS staff) and remaining appointed non-executives). Following an independent evaluation of the pilot, the Government decided in 2013 not to roll-out the pilot elections to other Health Boards, arguing that the pilot had not demonstrated improved public participation (BBC News Online, 2013).

Findings

This section reviews the evidence on the identified cases of elections to health bodies in order to ascertain the extent to which they created or enhanced the democratic credentials of health systems. Findings are discussed under the following themes, drawn from the conceptual framework outlined above and discussed in other published work (Greer et al 2014b): *authorization* (the evidence on how far specific elections can be considered democratic); evidence on the *accountability* of elected members to their publics; and finally, the extent to which elected members were able to *influence* decision-making once in place.

Authorization

There is no straightforward standard by which we can judge when an election is ‘democratic’. However there are some noteworthy aspects of elections which have been held to choose boards of healthcare organizations, and which prompt significant discussion within the academic and grey literature.

One issue which complicates any assessment of the democratic basis of authorization in the cases is the rapid abandonment of elections in the Scottish and Canadian cases. The promise of opportunities not only to elect, but also then to reject representatives at a future election (based on an assessment of their performance) is an important component of a democratic system. This also shapes the ongoing relationship between representative and represented (Dahl, 1961; Hooghe et al., 2013). That several Canadian provinces held only one election, and that in Scotland the elections were explicitly held as a pilot with no assurance that further elections would take place, arguably makes each of these an inadequately democratic form of authorization. While in New Zealand the long history of electing health bodies may increase public confidence in the ongoing value of their participation, the recent history of these elections is more fragmented (Laugesen & Gauld, 2012).

Within accounts of the electoral process for healthcare organizations, much of the literature is concerned with the vexed issues of levels of candidacy and turnout. These are seen as critical indicators of public engagement with the elections, and thus by extension, of the adequacy of authorization in each case. Table 1 shows election turnout across the systems where elections were held, and data is available.

[INSERT TABLE 1]

Comparing turnout across elections and systems is complicated, because of the small number of elections in most systems and because details of election process vary not just between but

also within systems over time. These include the choice of electoral system, whether postal voting was permitted or required, and whether ballot papers were for multiple elections. For example, New Zealand turnout figures include blank, spoiled, and invalid papers which are returned. Another factor likely to elevate turnout figures compared to other systems is the fact that it is usual for electors to be asked to vote in several different elections on the same ballot paper (perhaps voting for Health Board members on the same piece of paper as for a local mayor and councilors) (New Zealand Ministry of Health, 2014). In England, turnout figures appear artificially high because they are calculated as a percentage of the *membership* of the Trust, rather than of the potential local electorate. The overall figure also masks significant variation in turnout between Trusts (Ipsos MORI, 2008).

Nonetheless the table suggests some trends. Only one election, (New Zealand in 2001) achieved a turnout of 50% or more. Where more than one election is held, electoral turnout tends to fall over subsequent elections. New Zealand's 2010 election is a clear exception to this, in the context of a more gradual reduction in turnout than we see in other systems. Gauld (2010) suggests that the influence of postal voting contributes to these strong results. Gauld's 2007 post-election survey explored non-voters' rationales, and found the most common reasons were 'don't know' (35%), 'didn't know about elections' (19%), 'didn't receive voting papers' (12%) and 'no interest in elections' (17%). Lack of information about the Scottish health board elections also emerged as a significant theme in a survey of potential voters (Greer et al 2012).

The number of people standing as candidates is another indicator of public engagement with, and perceptions of the value, of elections. The general trend tends to be for the first election in a new system to yield high numbers of candidates. Scotland's pilot elections yielded unexpectedly high numbers of candidates (130 for 22 positions), creating administrative difficulties and voter confusion (Greer et al 2012). In English FTs the number of candidates per seat has fallen slightly over the years, and the number of uncontested elections increased from 24% to 47% between 2004 and 2011 (Monitor, Electoral Reform Services Research, & Membership Engagement Services, 2011). In New Zealand's first election (2001) a high number of candidates stood, but this has dropped off significantly in the subsequent two. Gauld (2010) states that there is no clear reason for this, but proposes disenchantment with the system, or simply a reduction in the initial excitement as potential explanations. In New Brunswick's elected Regional Health Authorities, levels of candidacy have been consistently lower (in the 2004 election, 110 candidates stood for 53 positions, and following the 2012 reintroduction of elections 79 candidates stood for 16 positions) (Elections New Brunswick, 2012).

Beyond the simple fact of their election by the public, it is relevant to consider how far the characteristics of the successful candidates enhance the descriptive representation of the citizenry within healthcare organizations. Representation of the Maori population is a major issue in New Zealand, and the continuing appointment of four members of each DHB is intended in part to deal with under-representation of Maoris through elections (Gauld, 2010). Maori representation through the elections did improve after the full introduction of STV in 2004 (Barnett et al., 2009) following a Government campaign to encourage Maori to stand as candidates and vote (Alliston & Cossar, 2006). Nonetheless the proportion of elected members of Maori ethnicity was only 8% in 2004 and 2007 (Gauld, 2010) (while the total population identifying as Maori in the 2006 census was 14.6%).

An interesting finding from several systems is that the public, rather than choose reforming ‘outsider’ candidates, tends to value a background working in healthcare over the financial, legal or management experience which is traditionally valued in appointed systems. Surveys indicate that the qualities sought in candidates in New Zealand have remained fairly stable across the three elections, with healthcare experience proving most popular (56% in 2007) and management or finance experience far less so (7% in 2007) (Gauld, 2010). In Scotland, successful candidates disproportionately had professional health service experience including doctors, nurses and hospital support staff (Greer et al 2014a). In English FTs, Day and Klein’s (2005) early study noted the election of high numbers of retired Governors and of Governors who have at some point worked in the NHS.

In sum, the evidence on the democratic credentials of the ‘authorisation’ offered in these elections is mixed, but not entirely encouraging. Much commentary on elections to healthcare organisations concentrates on electoral turnout as the defining indicator of success (see for example Lomas, 2001). On these terms, only the New Zealand elections come close to achieving and maintaining a democratic mandate. However there are other relevant facets of authorisation, not least the extent to which elections are competitive, and the demographic and professional characteristics of the representatives chosen.

Accountability

A democratic system requires not merely the fact of a (free and fair) election being held, but also an ongoing relationship between representative and public (Hooghe et al., 2013). The formal relationship of accountability between elected members and those they represent is complicated by the fact that in both Scotland and New Zealand, elected members are formally accountable not to their electorates, but to central Government. In practice, members might understand their accountability differently, and act accordingly. In Saskatchewan there were concerns about elected Boards being captured by sectional interests who would make decisions against the general good of the population (Lomas, 2001). However there was no evidence that elections had particularly politicized the Boards, and overall, Lewis et al (2001) found “surprisingly few differences in perception between elected and appointed members” in Saskatchewan. For example, 91% of elected Board members surveyed indicated that they would support a decision they believed to be right, even if it were opposed by the community, and 30% felt that their input to the Board was not strongly influenced by people in the community (Lewis et al., 2001). The Scottish study found that, while elected members expressed some confusion about their dual accountability, most accepted that they were primarily reporting to Central Government, and adopted similar perceptions of their role to that of previously appointed members (Greer et al 2014a). In the New Zealand case, Tenbensel et al (2011, p. 245) argued that “responsiveness to central government strategies has far outweighed the representation of local communities in decision making”.

Closely related to the question of how elected members understand their own accountability, is that of whether and how they develop mechanisms of ongoing engagement with their ‘constituents’. What seems apparent across the different health systems is that elections to

healthcare organizations do not carry with them a straightforward expectation of the sort of relationship we might expect between voter and elected member. The public role of FT Governors in England is slightly unclear. In one survey, 28% of Governors who responded had not been involved in any 'engagement' activities (Ipsos MORI, 2008). In two studies, the question of whether FT Governors should hold surgeries (in the way an MP or councilor might) had arisen (Ham & Hunt, 2008; Lewis & Hinton, 2008): while some governors were holding constituency meetings, these tended to attract only small numbers of the public, in other FTs governors had not felt confident or knowledgeable enough to do so, and in some the FT had taken the view that governors should not hold surgeries. However another project found that governors often saw themselves as a conduit between public and organization (Wright et al., 2012).

In New Zealand, legislation passed in 2000 created additional duties for Boards to hold meetings in public and to consult on strategic items (Tenbensel, Cumming, Ashton, & Barnett, 2008). In addition, DHBs were encouraged to create special mechanisms to consult with their Maori population, including agreements with existing Maori bodies (Alliston & Cossar, 2006; Boulton, Simonsen, Walker, Cumming, & Cunningham, 2004). One research project found that the combination of elected members and public Board meetings prompted a cultural change towards openness: Board meetings became slower moving, with the need to explain and reiterate for members of the public present (Barnett & Clayden, 2007). Barnett and Clayden (2007) found that Boards had very variable ways of engaging with their public including a public right to speak at Board meetings, and public road shows. However where community engagement had improved, they found no evidence that this was as a direct result of the presence of elected members (Barnett & Clayden, 2007). Gauld (2010, p. 377) similarly concludes that

“the New Zealand experience ... indicates that electoral mechanisms may play only a limited role in promoting participation, and could possibly counter public involvement...an elected board may be but one of multiple, parallel methods for public participation.”

Research in the Scottish pilots found that the presence of elected members had limited impact on public engagement (Greer et al 2014b). Day-to-day public engagement activity was largely seen as an operational matter, and Board membership was seen as a distinct strategic role. Elected members were discouraged by both central government and Board Chairs from developing a more public-facing role, which was seen as incompatible with corporate responsibility for Board decisions. The option of holding 'surgeries', where members of the public could come along to ask questions of their elected Board members, was raised but rejected in each Board – although in one Board one member insisted on holding such meetings without Board approval. Some elected members did not *want* to be more visible and available to the public, while others were frustrated, understanding this as a key purpose of their election.

In short, it does not seem that elected board members automatically feel that they should have the sort of relationship with electors found in other areas of democratic politics. In each system, despite differences, most board members seemed to find a somewhat less public-facing and publicly-responsive role, and took on a conventional sense of corporate responsibility for the board.

Influence

The literature points to two types of limitation on the power of elected members: the extent to which newly elected members are able to ‘steer’ the healthcare organization (internal influence); and the extent to which central government has devolved meaningful decision-making power to the organization within the health system (external influence).

Internal influence

The first of these issues arises in a number of the cases. It should be noted that ‘steering’ an organization is a challenge for boards of all healthcare organizations (Hunter, 1984; Klein, 1982; Wall, 1996), and not just those governed by elected Boards. However studies such as the Scottish research, where Board behavior was compared across elected and conventionally appointed Boards, allow a stronger basis for conclusions about the impact of elections. There was a moderate increase in levels of public disagreement within Scottish elected boards (which often value consensus), including public votes where there had been none previously, and requests to minute individual contributions and disagreements. Overall a greater diversity of perspectives was present in Board meetings. However the research was not able to assess whether this led to substantively different decisions being taken by Boards (Greer et al 2014b). Few members felt that their impact had been restricted *within* the Board, although members who had campaigned and been elected on platforms at odds with current Board strategy were more likely to feel frustrated with their potential for influence.

In English FTs, assessment of influence is complicated by the modest and somewhat vague aims of the elected element of the governance structure. Lewis and Hinton (2008) point out the challenges of evaluating a policy aim as modest as Boards of Directors ‘listening to’ their Governors. The potentially large number of Governors on any given Board suggests that Boards of Governors are intended as advisory, not decision-making bodies (Day & Klein, 2005). However Dixon, Storey and Rosete (2010) and Ham and Hunt (2008) agree that the statutory powers of Governors, especially around appointments and dismissal, ‘protect’ their status. Studies have found that most Governors have a fairly hands-off role, with most choosing not to attend meetings of the Board of Directors (Ham & Hunt, 2008); only 20% of Governors attend ‘all or most’ meetings of the Board (Ipsos MORI, 2008). The studies by Dixon, Storey and Rosete (2010) and Lewis and Hinton (2008) agree that Governors have not played a very influential role within organizations. Allen et al (2012) highlight very mixed views from Governors on their own influence, ranging from having more influence than expected, to feeling excluded from key business and not given access to papers. Lewis and Hinton (2008) found some disagreement between Governors and Directors over their appropriate role in decision-making, with some Governors keen to take strategic control, while others, and most Directors, preferred the Board of Governors to focus on ‘patient experience’.

External influence

As well as the extent to which elected representatives can meaningfully exert influence over the organisation they have been chosen to govern, there is evidence that in several systems elected representatives have been disappointed at the extent to which that organisation has meaningful autonomy within the wider health system. In New Zealand the literature clearly suggests that the main barriers to the effective influence of elected members are constraints imposed on Boards by central Government. Despite Boards spending time on prioritization exercises, one study found

“DHBs often lacked confidence that they could act on prioritization even if they wanted to, because they would not get such decisions past central government and/or the local community.” (Tenbensel et al., 2008)

Gauld (2010) found that some elected members presented themselves to their constituents as mere “Government messengers”. Barnett and Clayden (2007) similarly emphasize a lack of scope for District Health Boards to exert strategic direction, and Ashton (2005) discusses situations where Ministers have reversed DHB decision, undermining elected members. Most Board members see planning as developing a local version of national strategic plans, and accordingly influence is more likely to be over issues around service design and delivery (Tenbensel et al., 2008). The consensus seems to be that the shift to local decision-making has been outweighed by other, centralizing, policy trends (Ashton, Mays, & Devlin, 2005).

In Canada, frustration about a lack of Board autonomy was a notable finding in one study from Saskatchewan. 76% of all respondents (in a sample comprising 82% of elected and 64% of appointed members) agreed that Boards were legally responsible for things over which they had insufficient control, and 64% of elected respondents agreed they had less authority than they had expected when districts were formed (Lewis et al., 2001). In the Scottish study, many elected members of the Boards expressed surprise at the lack of room for manoeuvre Boards have, given the constraints of central Government funding, performance management and policy (Greer et al, 2014b). The external accountability of FTs has also been highlighted as a limitation on the influence available to elected Governors (Klein, 2003). One study concluded:

“Contrary to the major policy objectives of giving greater autonomy to FTs and making them more accountable to the local population, FTs continue to look up rather than down.” (Dixon et al, 2010)

Overall the question of whether elected representatives on Boards wield meaningful power either within their organizations or in the wider health system looms large in research from all four health systems studied. There is something of a consensus that their scope for action is constrained on multiple levels. While this is a common complaint at all levels in many political systems, it is, we would suggest, particularly problematic when a *new* system of elections is being built and expectations of meaningful power have been raised. It seems plausible that this could create a vicious circle with weak authorization and accountability of elected representatives.

Discussion

It is broadly accepted that health services must be accountable to the populations they serve, but the best means of accomplishing this varies across health systems. The intuitively obvious option of allowing the public to directly elect those who run their services clearly has some traction with politicians and policy-makers, as demonstrated by its recurring presence in a range of systems over four decades. However the research evidence paints a complex, and not entirely encouraging, picture of the likely success of this policy in democratizing healthcare organizations, and, through them, systems.

Research evidence demonstrates that a key challenge for this policy is the public response: turnout in elections to health organizations is low, and often falls in subsequent elections. This is not necessarily the critical blow that policymakers often seem to read it as, but it does lessen the legitimacy of the authorization. Low electoral turnout was a challenge for Foundation Trusts, Scottish Health Boards, and Canadian RHAs. While turnout has been higher for DHBs in New Zealand, it may have been reinforced not by public eagerness, but by the elections sharing a ballot paper with higher-profile elections. When it comes to finding members of the public keen to stand for election, experience is more mixed. Some Canadian provinces also had insufficient numbers of candidates and there is some concern that candidate numbers for Foundation Trusts are on a downward trend. In New Zealand candidate numbers have fallen but remained viable. Pilot elections in Scotland had such high numbers of candidates that voters struggled to process the necessary information. However the rich seam of (often qualitative) evidence on Boards in practice demonstrates that turnout and candidacy is not the end of the story.

In terms of elected Boards in practice, it must first be stressed – and a glance at most parliaments internationally would confirm – that elections do not guarantee a more descriptively representative group of Board members. In New Zealand, the continued appointment of a minority of Board members is intended in part to ensure adequate representation of minorities. What does consistently seem to change after elections is the skills mix on Boards. Many voters seem to value practical health service experience more than finance or management skills when choosing candidates. The accountability of members once elected does not appear to mirror the type of relationship which we would expect from an elected local government member or parliamentarian. A repeatedly troublesome issue is whether elected members should be available for members of the public to meet and air any concerns or grievances. Elected health board members seem unsure about the appropriate public role they should play, and in some cases have actively avoided a public-facing role, but it is difficult for elections to be meaningful without broader processes of political engagement. As Stoker (2006) puts it – “You can have politics without democracy... but you can’t have democracy without politics”.

Finally, in terms of the influence of elected members, elections seem to exacerbate some tensions in the nature and role of Boards within health systems. The mere fact of Board members’ election can raise expectations about their degree of influence. This highlights questions about the stated or actual function of Boards, with a distinction between small decision-making Boards (in political terms, an executive) and large, advisory or debating Boards (a legislature). Boards often focus mainly on day-to-day management, with strategic policy-making remaining with central or provincial Government. In New Zealand, Canada and Scotland some elected members were frustrated by these limitations on their influence, not within the Board, but within the wider health system.

Conclusion

The cases identified in this review are diverse in terms of the context of elections, and the technical details of the process instituted. However our review points to some common dilemmas and concerns which recur across time and place. One commentator summarized the Canadian experience with elected Boards thus:

“On one hand, such elections will not fracture accountabilities but will increase democracy. On the other hand, elections constitute an expensive additional process that will hardly change board outcomes and, besides, 10% voter turnout is not really democracy.” (Lomas, 2001)

While pointing to a major difficulty with elections across all the health systems except possibly New Zealand, we would argue that this statement under-estimates the complexity of what a democratic health system might mean. Notably, it is clear that holding an election is not the same as establishing an elected system. From related management literature on the role of Boards, we know that inserting a few ‘reforming’ individuals into a board which otherwise continues to operate as before is highly unlikely to be transformative (Alexander, Ye, Lee, & Weiner, 2006). Particularly in some Canadian provinces, and in Scotland, where elections were short-lived, entities which are only briefly elected are unlikely to establish an appropriately responsive relationship with their publics. Creating vague ‘Boards’ which exist not to decide, but merely to ‘be heard’ (as in English FTs), is unlikely to excite and mobilize publics to ‘get involved’. However the New Zealand case, where elected boards have been a recurring feature of the health system despite demonstrating many of the ‘evidence-based’ flaws which have scuppered them elsewhere, suggests that a history of elections builds a principled (or, more cynically, habitual) commitment to them which is difficult (although evidently not impossible) to overcome. This principled commitment was, in both the Scottish case (BBC News Online, 2013) and in several Canadian provinces (Lomas, 2001; Saskatchewan Health, 2001), outweighed by the financial costs associated with running large-scale elections. The Scottish research highlighted the relative costliness of an elected system, in comparison with other piloted methods of increasing Board ‘representativeness’ (Greer et al 2012).

These debates highlight the complexity of questions of accountability, participation and democracy in healthcare organizations. From the evidence on systems where elections to healthcare organizations have been held up to this point, elections are unlikely to be a silver bullet for a more democratic health system. This is particularly the case where they are introduced to organizations which are heavily circumscribed by central government policy and (perhaps as a result) lack visibility with their publics. Genuine efforts to reinvigorate the connection between local healthcare organizations and their publics will require a more thoroughgoing change in the role(s) these governing bodies play within the wider health system. The obvious alternative to introducing direct elections is to place health services, alongside other public services, under local government control. Local populations could then hold local politicians accountable for the performance of their health services. This option is familiar in Scandinavian models (Martinussen & Magnussen, 2009) and also currently being debated in England, where it is seen by some as a solution to the ongoing challenges of integrating health and social care services (Wright 2014). The relative potential of ‘stand-alone’ elected health authorities versus local government control in providing democratic authorization, accountability and influence within health systems is an important topic for future analysis. However, from previous experiences across four countries, the evidence for the democratizing potential of directly elected health authorities is far from convincing. The mere institution of elections is certainly not a silver bullet for the enduring challenge of building democratic health systems.

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Table

	First election turnout (%)		Second election turnout (%)		Third election turnout (%)		Fourth election turnout (%)		Fifth election turnout (%)	
New Zealand ²	2001	50	2004	46	2007	43	2010	49	2013	41
England ³	2004	48	2011	25						
New Brunswick ⁴	2004	47								
New Brunswick ⁵	2012	31								
Saskatchewan ⁶	1995	33	1997	25	1999	10				
Scotland ⁷	2010	16								

Table 1: Electoral turnout in elections to healthcare organisations

² Calculated from figures available in New Zealand Department of Internal Affairs (New Zealand Department of Internal Affairs, 2014)

³ Figures available in (Monitor, Electoral Reform Services Research, & Membership Engagement Services, 2011). FT elections do not happen at the same intervals, so these are collated figures for turnout from all elections in that year.

⁴ Figures available in (New Brunswick Office of the Municipal Electoral Officer, 2004)

⁵ Calculated from figures available in (Elections New Brunswick, 2012)

⁶ Figures available in (Saskatchewan Health, 2001)

⁷ Figures available in (*author citation*)